Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CROWN CHIROPRACTIC
2401 N ARKANSAS
LAREDO, TX 78043

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-5320-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At the time of exam Mr. [injured worker's name] continued to suffer pain to a compensable area. In the instance that the patient continues to suffer ongoing pain to not perform range of motion would be negligent. Given this fact of ongoing pain, a range of motion exam was needed to determine appropriate MMI/IR... Texas Mutual only paid $350.00 and owes a balance of $300.00 for one range of motion area."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The claimant was injured 10/13/09. 2. The requestor billed the base rate of the exam and billed the IR using the DRE method. Texas Mutual received the billing on 10/27/10, paid the MMI exam, and denied the IR indicating to the requestor the injury was minor. 3. Texas Mutual has no record of receiving a request for reconsideration of the initial reduction in payment. Nor has the requestor addressed the issue in his DWC-60 packet. For this reason Texas Mutual believes DWC MDR has no jurisdiction to proceed with a review absent the requestor required step of seeking reconsideration."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2009	99456-WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated November 20, 2009
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
   - PER RULE 134.202-IF THE EXAMINING DOCTOR DETERMINES MMI HAS BEEN REACHED AND THERE IS NO PERMANENT IMPAIRMENT BECAUSE THE INJURY WAS SUFFICIENTLY MINOR, AN IR EVALUATION IS NOT WARRANTED AND ONLY THE MMI EVALUATION PORTION SHALL BE BILLED AND REIMBURSED.

Issues

1. Has the Maximum Medical Improvement/Impairment Rating (MMI/IR) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The provider billed the amount of $500.00 for CPT code 99456-WP for a MMI/IR examination. Review of the documentation supports that MMI was assigned and one body area was rated. The respondent did not support their denial reason that the injury was sufficiently minor. Therefore Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the lumbar (spinal region) is $150.00. Therefore, the combined MAR for the MMI/IR exam is $500.00.
2. The respondent has paid $350.00 for CPT code 99456-WP and additional reimbursement of $150.00 is recommended.

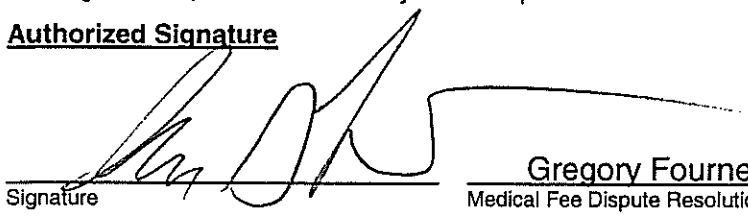
Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature | Gregory Fournerat, Medical Fee Dispute Resolution Officer | November 4, 2011, Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.